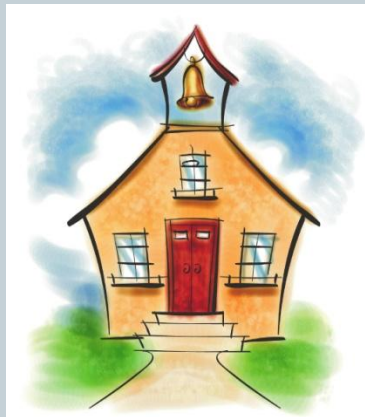


New Employee Orientation



2011-2012 SCHOOL YEAR

Weakley County Schools



Welcome Letter



WEAKLEY COUNTY DEPARTMENT OF FINANCE

Shawn Francisco, Director of Finance
8519 Highway 22, Suite B
Dresden, TN 38025
E-mail: francisco@k12tn.net
www.weakleycountyn.gov
T: (731) 364-5429 F: (731) 364-3858

We want to welcome each of you to the Weakley County School System. Below is information that may be helpful concerning your pay and benefits.

You have been provided a salary schedule in your packet. Your gross monthly salary will be equal to the salary based on your education level and your years of experience divided by twelve.

You are paid based on a 200 day contract of which 180 are work days, 5 are in-service, 5 are workdays, and 10 are holidays (earn 1 holiday for every 20 days you work).

You will be paid on the 15th of every month unless the 15th falls on a Saturday or Sunday then you will be paid on the Friday before the 15th. Your first check is September 15, 2011.

Your summer pay stubs for June and July will not be mailed unless you provide a self-addressed stamped envelope to the Weakley County Department of Finance. The stubs that are not picked up or mailed will be sent to the school in August.

You will earn 10 sick days and 2 personal days per year. You earn one sick day for every twenty days you work. You earn one personal day for every one hundred days you work. You are allowed to use your sick days before you earn them; however, deductions will be made immediately from check if you have a negative balance.

Your physicals must be completed by October 1st if this is not done you will not receive your October check until it is completed.

You are eligible for a \$10 match per month for participating in a tax-deferred annuity program. The minimum for your contribution is \$50. The following companies are participating vendors:

Horace Mann: Customer Service: 1.800.999.1030
Woodmen of the World: Reps: David Spencer 731-587-9635
Nationwide Retirement: 1-877-677-3678

You are eligible for Usable Life and Aflac. Products are disability, life, cancer, accident, etc. Usable will be at your school in August or September. Our representative is Alan Cary, 731.587.3033. Our Aflac agent is Vicki Hill, 731.281.4014.

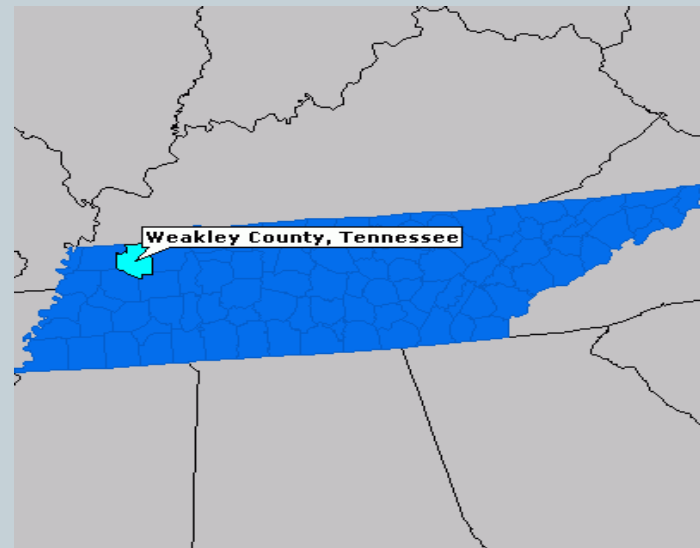
You are eligible to participate in the Weakley County Government Employees Credit Union. The minimum contribution is \$5 per month. It earns interest similar to a savings account. Once a member you are eligible for personal loans and car loans.

If you were a licensed substitute teacher, you may be eligible for experience credit. If you taught in school systems besides Weakley County contact the Personnel Department and request that your experience be submitted to the State.

If you have any other questions, please feel free to contact me.

Thank you,

Shawn Francisco,
Director of Finance





Teacher's Salary Schedule



2011-2012 WEAKLEY COUNTY TEACHERS' SALARY SCHEDULE

EXPERIENCE		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21-24	25
DEGREE																								
BACHELORS	SALARY TOTAL	32,950	34,319	34,319	34,494	34,855	35,387	35,887	36,356	36,878	37,504	37,960	38,546	39,003	39,561	40,027	40,810	40,880	41,154	41,220	41,490	41,676	42,087	42,311
MASTERS	SALARY TOTAL	35,535	36,951	37,108	37,291	37,734	38,406	38,909	39,540	40,256	41,109	41,299	42,185	42,365	43,279	43,516	44,433	44,513	45,123	45,172	45,952	45,952	46,376	46,594
MASTERS + 30	SALARY TOTAL	37,993	39,420	39,574	39,770	40,162	40,869	41,371	41,981	42,659	43,573	43,783	44,725	44,863	45,859	45,981	47,022	47,092	47,809	47,827	48,754	48,872	49,353	49,579
ED.S.	SALARY TOTAL	38,846	40,123	40,175	40,642	41,071	41,743	42,456	43,362	44,631	45,592	45,783	46,750	46,952	47,961	48,163	49,288	49,291	50,272	50,282	51,285	51,285	51,884	52,128
DOCTORATE	SALARY TOTAL	41,540	42,826	42,878	43,277	43,925	44,822	46,038	47,010	48,639	49,450	49,643	50,688	50,905	52,010	52,200	53,406	53,409	54,487	54,494	55,606	55,718	56,228	56,478

New Teacher Checklist



New Teacher Checklist

Name: _____

School: _____

- New Hire Report
- W-4 Form
- I-9 Form
- Copy of 2 Forms of I.D. (Example: Driver's License/Social Security Card)
- Direct Deposit Acknowledgement Form
- Tennessee Consolidated Retirement Form (TCRS)
- Employee Insurance Checklist
- Insurance Enrollment/Change Application
- Dental Selection Card (Assurant Plan Only)
- Policy Acknowledgement Card
- Physical Form
- Teaching Certificate
- Experience From Prior Schools
- Sick Days from Prior Schools
- Signed Contract



Code of Ethics



CODE OF ETHICS WEAKLEY COUNTY, TENNESSEE

Definitions.

- (1) "County" means Weakley County, which includes all boards, committees, commissions, authorities, corporations or other instrumentalities appointed or created by the county or an official of the county, and specifically including the county school board, the county election commission, the county health department, and utility districts in the county.
- (2) "Officials and employees" means and includes any official, whether elected or appointed, officer, employee or servant, or any member of any board, agency, commission, authority or corporation (whether compensated or not), or any officer, employee or servant thereof, of the county.
- (3) Personal interest means, for the purpose of disclosure of personal interests in accordance with this Code of Ethics, a financial interest of the official or employee, or a financial interest of the officials or employees spouse or child living in the same household, in the matter to be voted upon, regulated, supervised, or otherwise acted upon in an official capacity.

Disclosure of personal interest in voting matters. An official or employee with the responsibility to vote on a measure shall disclose during the meeting at which the vote takes place, before the vote and to be included in the minutes, any personal interest that affects or that would lead a reasonable person to infer that it affects the officials vote on the measure. In addition, the official or employee may, to the extent allowed by law, recuse himself or herself from voting on the measure.

Disclosure of personal interest in non-voting matters. An official or employee who must exercise discretion relative to any matter other than casting a vote and who has a personal interest in the matter that affects or that would lead a reasonable person to infer that it affects the exercise of the discretion shall disclose, before the exercise of the discretion when possible, the interest on the attached disclosure form and file the disclosure form with the county clerk. In addition, the official or employee may, to the extent allowed by law, recuse himself or herself from the exercise of discretion in the matter.

Acceptance of gifts and other things of value. An official or employee, or an official's or employee's spouse or child living in the same household, may not accept, directly or indirectly, any gift, money, gratuity, or other consideration or favor of any kind with a value greater than \$50.00 per day from anyone other than the county.



New Hire Report



STATE OF TENNESSEE NEW HIRE REPORTING

Effective October 1, 1997, all Tennessee employers are required to report certain information about employees who have been newly hired, rehired, or have returned to work. Employers must either (1) complete this form, or (2) submit a copy of the employee's IRS W-4 form, (3) other form with required information at a minimum, or (4) submit the information by Internet, magnetic tape or diskette. This form may be reproduced as necessary. Reports made on this form must be within 20 calendar days of hire or if you wish to help the Department of Labor and Workforce Development, within 5 days of date of hire.

TO ENSURE ACCURACY, PLEASE PRINT (or TYPE) NEATLY IN UPPER-CASE
LETTERS AND NUMBERS, USING A DARK, BALL-POINT PEN

REQUIRED INFORMATION:		EMPLOYEE DATA
Social Security Number: <input type="text"/> - <input type="text"/> - <input type="text"/>		
Name: <input type="text"/> <small>First</small> <input type="text"/> <small>M.I.</small> <input type="text"/> <small>Last</small>		
Home Address: <input type="text"/>		
City: <input type="text"/> State: <input type="text"/> Zip Code: <input type="text"/>		
Employee Date of Hire: <input type="text"/> - <input type="text"/> - <input type="text"/>		
Federal EIN: <input type="text"/> - <input type="text"/>		EMPLOYER DATA
Employer Name: <input type="text"/>		
Address: <input type="text"/>		
City: <input type="text"/> State: <input type="text"/> Zip Code: <input type="text"/>		

ADDITIONAL INFORMATION:

Store or Outlet Number:

Gender (M/F): Employee State of Hire: Date of Birth: --

Earned Income Tax Credit Available? (Y/N): ☐ Employee Left Your Employment? (Y/N): ☐
(If unknown, leave blank) (Has this employee left your employment before you filed this report?)

Does your company offer Medical Insurance? (Y/N): ☐

Corporate or Payroll Address:
(if different from business address) City: State: Zip Code:

REPORTS WILL NOT BE PROCESSED WITHOUT MANDATORY INFORMATION

Send Reports To: Tennessee New Hire Reporting Program
P.O. Box 17367
Nashville, Tennessee 37217
Fax: (615) 506-4761

W-4 Form



Form W-4 (2011)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 begins February 15, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$200 and exceeds more than \$200 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. This worksheet on page 2 further explains your withholding allowances, subject to federal deductions, certain credits, adjustments to income, or tax-exempt multiple job situations.

Personal Allowances Worksheet (Keep for your records.)

<p>A Enter "1" for yourself if no one else can claim you as a dependent.</p> <p>B Enter "1" if:</p> <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less. <p>C Enter "1" for your spouse. But, you may choose to enter "0" if you are married and have either a working spouse or more than one job. (Entering "0" may help you avoid having too little tax withheld.)</p> <p>D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.</p> <p>E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above).</p> <p>F Enter "1" if you have at least \$1,000 of child or dependent care expenses for which you plan to claim a credit. (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)</p> <p>G Child Tax Credit (providing additional child tax credit). See Pub. 572, Child Tax Credit, for more information.</p> <ul style="list-style-type: none"> • If your total income will be less than \$10,000 (\$8,000 if married), enter "0". If you have three or more eligible children, if your total income will be between \$80,000 and \$94,000 (\$60,000 and \$71,000 if married), enter "1". For each eligible child plus "1" additional if you have six or more eligible children. <p>H Add lines A through G and enter total here. Note. This may be different from the number of exemptions you claim on your tax return. H</p> <p>For accuracy, complete all worksheets that apply:</p> <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income (and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2). • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$60,000 (\$72,000 if married), see the Two-Earnings/Multiple-Job Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 6 of Form W-4 below. 	<p>A</p> <p>B</p> <p>C</p> <p>D</p> <p>E</p> <p>F</p> <p>G</p>
--	---

Cut here and give Form W-4 to your employer. Keep the top part for your records.

<p>Form W-4 Employee's Withholding Allowance Certificate</p> <p><small>Department of the Treasury Internal Revenue Service</small></p>		<p>OMB No. 1545-0047 2011</p>
<p>1 Type or print your first name and middle initial.</p>		<p>2 Your social security number.</p>
<p>3 Last name.</p>		
<p>4 Home address (permanent or usual or care-mailing). City or town, state, and ZIP code.</p>		
<p>5 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withheld at higher Single rate. <i>Note.</i> If married, but jointly-owned or -owned as a community state, check the "Single" box.</p> <p>6 If your last name differs from that shown on your most recent payroll card, check here. You must call 1-800-772-1012 for a replacement card. <input type="checkbox"/></p>		
<p>7 Total number of allowances you are claiming from line H above on the applicable worksheet on page 2.</p> <p>8 Additional amount, if any, you want withheld from each paycheck.</p> <p>9 I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption:</p> <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. <p>If you meet both conditions, write "Exempt" here. <input type="checkbox"/> EX</p>		
<p><small>Under penalty of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.</small></p>		
<p>Signature's signature (This form is not valid unless you sign it.)</p>		<p>Date</p>
<p>10 Employer's name and address. Employer: Complete lines 9 and 10 only if sending to the IRS. 11 Tax-exempt employer 12 Employer identification number (EIN)</p>		

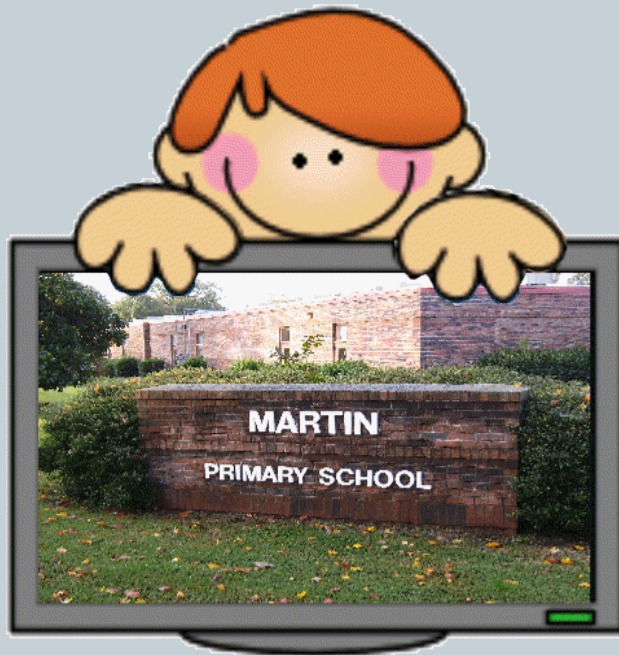
For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Gen. No. 1022002

Form W-4 (2011)



I-9 Form



Department of Homeland Security
U.S. Citizenship and Immigration Services

OMB No. 1615-0047; Expires 06/30/09
**Form I-9, Employment
Eligibility Verification**

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)			Apt. #
City			State
Zip Code			Date of Birth (month/day/year)
			Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
☐ A noncitizen national of the United States (see instructions)
☐ A lawful permanent resident (Alien #) _____
☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year) _____

Employee's Signature

Date (month/day/year)

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature

Print Name

Address (Street Name and Number; City, State, Zip Code)

Date (month/day/year)

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number; City, State, Zip Code)		Date (month/day/year)

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
Document Title	Document #
Expiration Date (if any):	Expiration Date (if any):
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.	
Signature of Employer or Authorized Representative	Date (month/day/year)

Direct Deposit Form



**COUNTY OF WEAKLEY
DEPARTMENT OF FINANCE
AUTHORIZATION FOR AUTOMATIC PAYROLL DEPOSIT**

Are you currently drawing a Tennessee Consolidated Retirement check? Yes or No

NAME: _____

SOCIAL SECURITY NUMBER: _____

BANK NAME: _____

CITY, STATE: _____

CHECKING ACCOUNT #: _____

AND/OR

SAVINGS ACCOUNT #: _____

ROUTING/TRANSIT/ABA NUMBER: _____

PLEASE ATTACH A VOIDED CHECK.

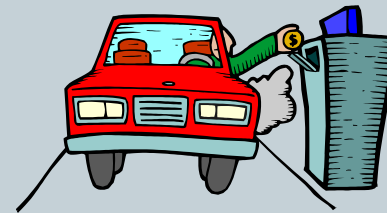
I hereby authorize the Weakley County Department of Finance to automatically deposit my payroll check into the above account(s).

PRINTED NAME: _____

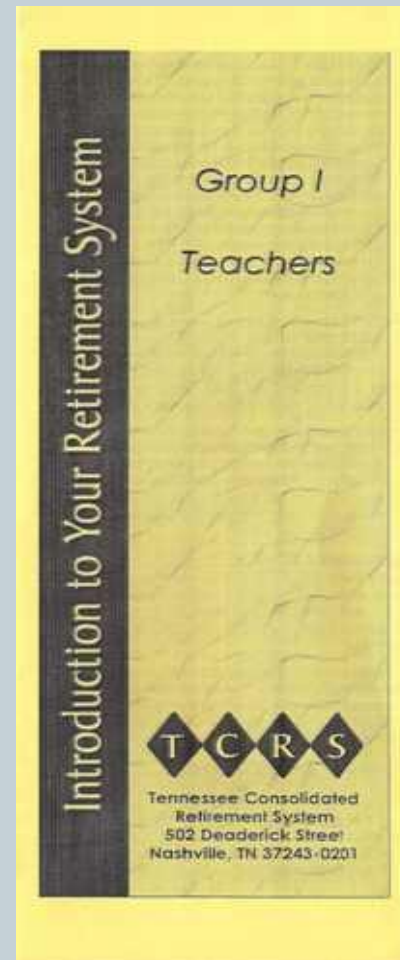
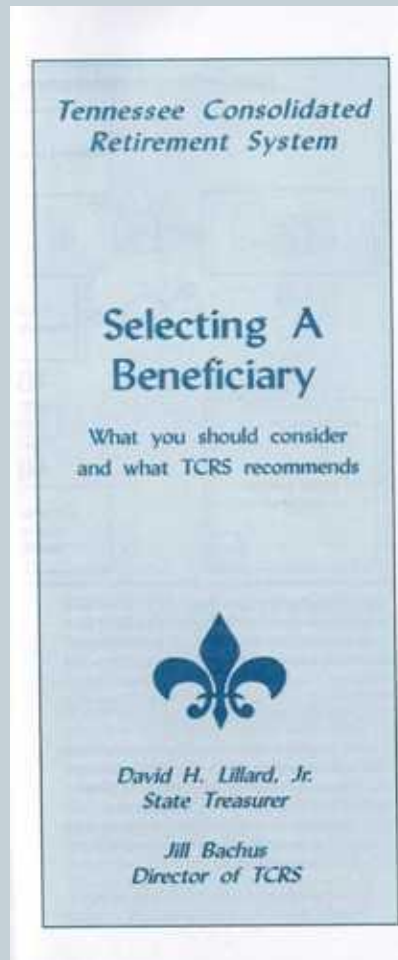
SIGNATURE: _____

DATE: _____

**** IF YOU SHOULD HAVE ANY CHANGES, BE SURE TO SEND THE DEPARTMENT OF FINANCE WRITTEN NOTIFICATION IN A TIMELY MANNER.**



Tennessee Consolidated Retirement System



TCRS Membership Form



	MEMBERSHIP FORM	TENNESSEE CONSOLIDATED RETIREMENT SYSTEM 502 Deaderick Street Nashville, TN 37243-0201 (615) 741-4868
	Type or print legibly in BLACK ink. The payroll/personnel officer must complete the shaded areas. Not to be used as a Change of Beneficiary Form.	

Type or print legibly in BLACK ink. The payroll/personnel officer must complete the shaded areas. Not to be used as a Change of Beneficiary Form.

☐ New Member ☐ Transfer from Another TCRS Agency

Member Information

Social Security Number		Birth Date	
Last Name		First Name	Sex
Address			
City		State	Zip
Home Telephone		Work Telephone	
Membership Date	Department Code	Retirement Type	
Employment (check one) <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Employment Date		
Status <input type="checkbox"/> Regular <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary <input type="checkbox"/> Interim <input type="checkbox"/> Emergency	hours per day	days per week	
If teacher, total months worked per year <input type="checkbox"/> 10 <input type="checkbox"/> 12 Title of Position			
Date first deduction will be made		Payroll Officer	Telephone #

Previous Employment—Fill out this section if you have ever been a member of any state or local retirement system.

Name of retirement system(s) other than TCRS:
Name(s) under which you were listed:
Have you ever been refunded your contributions with the TCRS?
Have you ever received benefits from TCRS?

Beneficiary Designation

Last Name	First Name	Relationship	Sex	Birth Date	Social Security No.

Name of Institution or Estate	Taxpayer I.D.	Address

Signature of Member	Date

The laws governing TCRS provide that you may designate more than one person as your beneficiary. For TCRS purposes, the term "person" means any individual, firm, organization, partnership, association, corporation, estate, or trust. **ESTATES, MULTIPLE BENEFICIARIES, AND INSTITUTIONS ARE ELIGIBLE FOR LUMP-SUM DISTRIBUTIONS ONLY. IF YOU LIST TWO OR MORE PERSONS, YOU HAVE NAMED MULTIPLE BENEFICIARIES AND THEY MAY SHARE EQUALLY IN ANY LUMP-SUM PAYMENT. IF YOU HAVE NEVER MADE CONTRIBUTIONS TO TCRS, NO LUMP-SUM PAYMENT WILL BE MADE AND YOUR SPOUSE MAY BE THE ONLY PERSON ELIGIBLE FOR ANY TYPE DEATH BENEFIT.** Certain types of death benefits are payable only to a surviving spouse, provided such spouse is the only person named as beneficiary. If you name your spouse as beneficiary, he or she may be entitled to monthly benefits should you die in service. (Secondary or contingent beneficiaries are not permitted.) Contact the TCRS office if you have any questions. If available, I select Option 1 for my beneficiary in the event of my death. I, the member, revoke any previous beneficiary nominations and direct that the above designation supersede any previously filed; provided, however, in the event I named my spouse and another person or persons as beneficiary herein and no death benefit is payable as a result thereof, I direct TCRS to revoke such designation and substitute my spouse instead as sole beneficiary.

STATE OF TENNESSEE—COUNTY OF _____
_____ personally appeared before me on this _____ day _____, 20____
who makes oath that (he) (she) executed the foregoing instrument.

Notary Signature and Seal _____ My Commission Expires: _____

After completing form, make two copies. Original—TCRS; Copy—Agency; Copy—Employee

TR-0353 (Rev. 10/05)

RDA413



Physical Form



WEAKLEY COUNTY GENERAL MEDICAL EXAMINATION RECORD FOR TEACHING

PHYSICIAN'S EXAMINATION

This report is confidential.

NAME _____
Last First Middle

Date of Birth _____ Race _____ Sex _____ Marital Status _____

Height _____ Weight _____ Average Weight for height _____

Name of all illnesses or injuries occurring in past five years _____

Vision: Without Glasses: R 20/ _____ L 20/ _____ With Glasses: R 20/ _____ L 20/ _____

Skin _____ Feet _____ Varicose Veins _____ Posture _____

Lymph Glands _____ Orthopedic _____ Breasts _____

Thyroid _____ Teeth _____ Gums _____

Ears: R _____ L _____ Nose _____ Throat _____ Tonsils _____

Heart _____ Blood Pressure _____ Pulse _____

Arteriosclerosis _____ Dyspnea _____ Edema _____

Lungs _____ X-Ray _____ Date of X-Ray _____

Abdomen _____ Hernia _____ Nervous System _____

Examination if indicated: Genitourinary _____

AnoRectal _____ Pelvis _____

Laboratory urine examination _____ Blood test _____

After careful examination, do you find applicant physically and emotionally sound?
Yes _____ No _____

If not, give reasons _____

Date _____ M.D.

Printed name of above signature: _____

Employee Acknowledgement Card

- Located inside
Personnel Handbook



EMPLOYEE ACKNOWLEDGMENT

By signing this form, I acknowledge that I have received a copy of the personnel policies currently in effect for my office as of this date, and I understand that it is my responsibility to read and comply with the policies. These policies cannot and are not intended to answer every question about my employment with Weakley County. I understand that I should consult my supervisor or the payroll office regarding any part of the policies that I do not understand or any questions I may have about my employment with Weakley County that are not answered in the policies. The current policies will always be on file in the office of the Weakley County Clerk, and I may examine them there at any time during normal business hours.

The policies are necessarily subject to change, and I acknowledge that revisions may occur from time to time. I understand that all changes to the policies will be filed in the office of the Weakley County Clerk. Although my employer will usually provide me with notice of changes, I understand that changes will apply to me regardless of whether I receive actual notice. I understand that revised information may supersede, modify or eliminate any or all of the policies at any time. All information contained in the policies is subject to applicable state and federal laws, rules and regulations, and I understand that to the extent that any such laws may conflict with any provision of the policies, such laws, rules and regulations will control.

I acknowledge that none of the County's policies may be construed to create a contract of employment or any other legal obligation, express or implied, and that any policy may be amended, revised, supplemented, rescinded or otherwise altered, in whole or in part, at any time, in the sole and absolute discretion of Weakley County.

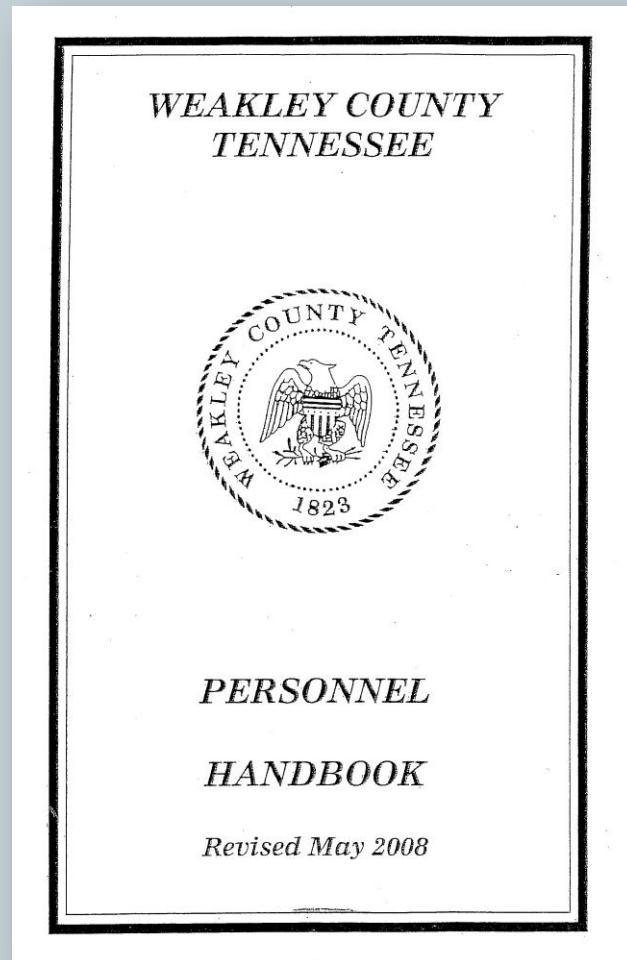
Employee Name (type or print)

Employee Signature

Date



Personnel Handbook





ANY QUESTIONS SO FAR?



- Feel free to ask questions- that's why we're here.
- Now let's talk about health insurance.



Local Education Checklist



STATE OF TENNESSEE GROUP INSURANCE PROGRAM EMPLOYEE INSURANCE CHECKLIST — LOCAL EDUCATION PLAN State of Tennessee • Department of Finance and Administration • Benefits Administration 20th Floor, William R. Smithers TN Tower • Nashville, Tennessee 37243

DO NOT submit this form to Benefits Administration. This form must be completed during an employee's initial enrollment period. After completion, this form is to be placed in the employee's insurance or personnel file at the time of processing. Place a check mark after each action has been completed.

EMPLOYEE INFORMATION

Name: _____ Social Security Number: _____ Agency: _____

ELIGIBILITY AND ENROLLMENT

- ☐ Explain the eligibility criteria for employees and dependents.
- ☐ Enrollment applications must be returned by _____.
Advise of the importance of enrolling during the initial enrollment period. If not enrolled when first eligible, they will only be allowed insurance coverage by approval through one of the special enrollment processes. There is no guarantee of an open enrollment in future years. If a completed enrollment application is not returned by the 15th of the month prior to coverage beginning, an employee may have a double deduction on the first paycheck from which health premiums are collected.
- ☐ Explain the Annual Enrollment Transfer Period, which occurs each year during the fall.
 - Employees/dependents are allowed to transfer between or cancel health options.
 - Employees/dependents are allowed to enroll in, transfer or cancel dental coverage.
 - Employees/dependents are allowed to enroll in optional life insurance coverage.
 - Effective dates for any changes will be the following January 1.

INSURANCE PRODUCTS

Health Options

- ☐ Partnership PPO
 - available statewide
- ☐ Standard PPO
 - available statewide

Dental Options

- ☐ Preferred Plan
- ☐ Preferred Dental Organization (PDO)

MATERIALS TO BE PROVIDED

- ☐ Provide an enrollment/change application and optional life insurance applications. Enrollment application must be signed and placed in the employee's insurance/personnel file when if enrolling coverage.
- ☐ Provide a SunCare notice to make employees aware of their responsibility if they or their dependents are currently enrolled in SunCare.
- ☐ Provide premium amounts for appropriate health and dental programs.
- ☐ Provide a copy of the eligibility and enrollment handbook, HIPAA privacy statement brochure and applicable provider materials including a provider directory.
- ☐ Explain the benefits available through the Employee Assistance Program (EAP) and provide brochures.

Employee Signature _____

Agency Benefits Coordinator Signature _____

Date _____

Date _____

DY0881 (rev 12/10)



Local Education Health Enrollment Form



STATE OF TENNESSEE GROUP INSURANCE PROGRAM
HEALTH / DENTAL ENROLLMENT CHANGE APPLICATION
 State of Tennessee • Department of Finance and Administration • Benefits Administration
 312 West L. Wolfe Avenue • Suite 2600 • Nashville, TN 37243 • Fax: 615.741.8198

PARTNERS FOR HEALTH
 EMPLOYEE OR COBRA

Part 1: Action Requested

Type of Action: <input type="checkbox"/> Add Coverage <input type="checkbox"/> Change Coverage <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Update Personal Info	Coverage Affected: <input type="checkbox"/> Health <input type="checkbox"/> Dental	Participants Affected: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Children	Reason for This Action: <input type="checkbox"/> New Hire/Newly Eligible <input type="checkbox"/> Terminate Employment <input type="checkbox"/> Special Qualifying Event (also complete page 3) <input type="checkbox"/> Court Order <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Marriage/Adoption <input type="checkbox"/> Other (specify)	<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death
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Part 2: Employee Information

First Name: _____ Last Name: _____ Date of Birth: _____ Gender: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W
 Social Security Number: _____ Employing Agency: _____ Employer Group: ☐ State ☐ Local Gov ☐ Other Current Status: ☐ Active ☐ COBRA
 Home Address: _____ Update my address ☐ City: _____ ST: _____ ZIP Code: _____ County: _____

Part 3: Health Coverage Selection

Select a Benefit Option: ☐ Standard PPO ☐ Partnership PPO ☐ Limited PPO (available to local government only)
 Select a Carrier: ☐ BlueCross BlueShield of Tennessee ☐ CIGNA Open Access Plus
 Select a Region Where You Live or Work: ☐ East ☐ South ☐ West
 See page 4 for map and information for out of state residents.
 Select a Health Premium Level: ☐ employee only ☐ employee + spouse ☐ employee + spouse + child(ren) ☐ employee + spouse + child(ren)

Part 4: Dental Coverage Selection

Select a Plan: ☐ Delta Preferred Dental Organization ☐ Assurant Prepaid Plan
 Check with your agency to see if you are eligible for dental coverage.
 Select a Dental Premium Level: ☐ employee only ☐ employee + spouse ☐ employee + spouse + child(ren) ☐ employee + child(ren)

Part 5: Dependent Information - attach a separate sheet if necessary

Relationship (e.g., wife)	Date of Birth	Relationship	Gender	Marital Status	Social Security Number	Health	Dental
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>	<input type="checkbox"/>

* The spouse date is the date of marriage, birth, adoption or guardianship.
 Proof of a dependent's eligibility must be submitted with this application for all new dependents (see page 2).
 A separate sheet with more dependent information is attached.

Part 6: Employee Authorization

☐ Agree: I confirm that all of the information above is true. If I choose the Partnership PPO, then I agree to the terms and conditions of the Partnership Premium for the plan year indicated on page 4. I know that I can lose my insurance if I give false information. I may pay more deductibles and legal charges. If my dependent loses eligibility, I know that I must tell my benefits coordinator within five working days. If I do not, then I will have to pay the plan back for all of my dependent's health care bills. I authorize my employer to take deductions from my paycheck to pay for my benefits costs. Finally, I authorize the/their provider to give my insurance carrier the medical and insurance records for me and my dependents.
☐ Refuse: I have been given the opportunity by my employer to apply for the group insurance program and have decided not to take advantage of this offer. I understand that if I take such to apply, I or my dependents will have to provide proof of a qualifying event.

Employee Signature: _____ Date: _____ Home Phone: _____

Agency Section - Return this form to your Agency Benefits Coordinator

Original Hire Date: _____ Coverage Begins/End Date: _____ Plan/Plan Number: _____ Edition: _____ (Optional) Notes to Benefits Administration: _____
 Agency Benefits Coordinator Signature: _____ Date: _____

Active employees should return this completed form to your agency benefits coordinator. COBRA participants should send to Benefits Administration. (A-104)



Dependent Eligibility Form



DEPENDENT ELIGIBILITY

Definitions and Required Documents (rev 7/20/10)

**PARTNERS
FOR HEALTH.**

TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	Page 1 and signed and dated signature page of participant's prior year Federal Income Tax Return (1040, 1040A or 1040EZ) listing the spouse's name and marked either married filing jointly or married filing separately; or Page 1 and Certificate of Electronic Filing (must show as accepted) of participant's prior year Federal Income Tax Return (1040, 1040A or 1040EZ) listing the spouse's name and marked either married filing jointly or married filing separately; or Marriage certificate and one of the following: • Proof that participant and spouse own a home or other real estate together • Proof that participant and spouse are both listed on a lease or share the rent of a home or other property • A utility bill with both names • Proof of a jointly-owned bank or financial account • Proof of a joint loan or debt obligation If just married in the current calendar year, a marriage certificate only is acceptable proof of eligibility
Natural (biological) child under age 26	A natural (biological) child	The child's birth certificate; or Certificate of Report of Birth (DS-1350); or Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); or Certification of Birth Abroad (FS-545)
Adopted child under age 26	A child the participant has adopted or is in the process of legally adopting	Court documents signed by a judge showing that the participant has adopted the child; or International adoption papers from country of adoption; or Papers from the adoption agency showing intent to adopt
Child for whom the participant is legal guardian	A child for whom the participant is the legal guardian	Any legal document that establishes guardianship
Stepchild under age 26	A stepchild	Verification of marriage between employee and spouse and birth certificate of the child showing the relationship to the spouse; or Any legal document that establishes relationship between the stepchild and the spouse or the member
Child for whom the plan has received a Qualified Medical Child Support Order	A child who is named as an alternate recipient with respect to the participant under a Qualified Medical Child Support Order (QMCSO)	Court documents signed by a judge; or Medical support orders issued by a State agency
Disabled dependent	A dependent of any age (who falls under one of the categories previously listed) and due to a mental or physical disability, is unable to earn a living. The dependent's disability must have begun before age 26 and while covered under a State-sponsored plan.	Documentation will be provided by the insurance carrier at the time incapacity is determined

Never send original documents. Please mark out or black out any Social Security numbers and any personal information.



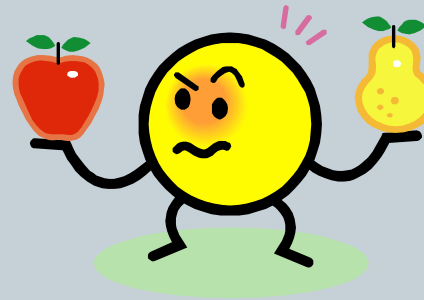
Insurance Rates

WEALKEY COUNTY LOCAL EDUCATION HEALTH INSURANCE RATES EFFECTIVE JANUARY 1, 2011

PLAN	PLAN TYPE	TOTAL PREMIUM	COUNTY SHARE	EMPLOYEE SHARE
CIGNA - WEST				
PARTNERSHIP PPO	EMPLOYEE ONLY	\$ 468.90	\$ 351.68	\$ 117.22
	EMPLOYEE+CHILD(REN)	773.69	504.07	269.62
	EMPLOYEE+SPOUSE	914.36	574.41	339.95
	FAMILY	1,219.14	726.80	492.34
STANDARD PPO	EMPLOYEE ONLY	\$ 493.90	\$ 370.43	\$ 123.47
	EMPLOYEE+CHILD(REN)	798.69	522.82	275.87
	EMPLOYEE+SPOUSE	964.36	605.66	358.70
	FAMILY	1,269.14	758.05	511.09
BLUE CROSS BLUE SHIELD - WEST				
PARTNERSHIP PPO	EMPLOYEE ONLY	\$ 478.90	\$ 359.18	\$ 119.72
	EMPLOYEE+CHILD(REN)	793.69	516.57	277.12
	EMPLOYEE+SPOUSE	934.36	586.91	347.45
	FAMILY	1,239.14	739.30	499.84
STANDARD PPO	EMPLOYEE ONLY	\$ 503.90	\$ 377.93	\$ 125.97
	EMPLOYEE+CHILD(REN)	818.69	535.32	283.37
	EMPLOYEE+SPOUSE	984.36	618.16	366.20
	FAMILY	1,289.14	770.55	518.59

WEAKLEY COUNTY PAYS 75% OF THE TOTAL PREMIUM OF THE EMPLOYEE ONLY COST PLUS 50% OF THE ADDITIONAL COST FOR DEPENDENTS.

WEAKLEY COUNTY IS PREMIUM LEVEL 1.



TennCare Notice



Are You or Your Dependents Insured by TennCare?

Regular full-time employees of participating agencies of state government, local education agencies and local government agencies and their dependants are eligible for health insurance through a state-sponsored medical plan.

If you and/or your dependents are currently enrolled in TennCare you are required to contact your caseworker at the Department of Human Services within 10 days of your date of employment. You need to report your new job, salary and that you have access to medical insurance with your employer. If you have elected to sign up for state-sponsored medical insurance you will need to provide your DHS caseworker with the date your coverage will begin and the name of the insurance carrier.

TennCare could determine that you would still be eligible to continue the TennCare coverage. **If TennCare cancels your coverage or the coverage of your dependents at some future date, you will have 60 days from the termination date to apply to your employer for coverage on the state-sponsored plan.** You may also contact the State Division of Insurance at 1-800-253-9981 for instruction on how to apply after TennCare has cancelled your coverage.

Tennessee Code Annotated 71-5-118

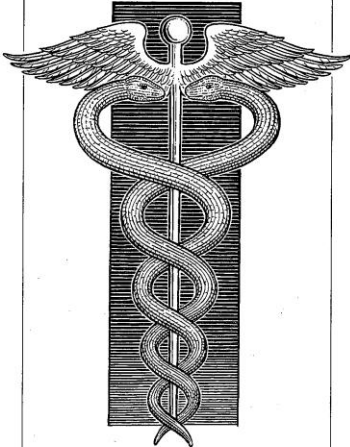
It is now a felony offense to obtain TennCare coverage under fraudulent means. Violators, if convicted, can be sent to prison.

It is now a felony offense for a person to knowingly obtain, attempt to obtain or aid and abet any other person to obtain, by fraudulent, means any coverage provided to TennCare enrollees.

In addition to any penalties for a felony offense, any person committing the offense and violating the law may be disqualified from participating in the TennCare Program as an enrollee.

Cobra Notification and HIPPA

CONTINUING INSURANCE THROUGH
COBRA



Eligibility rules for participation in the state group insurance program through COBRA are based on the policies of the group insurance program and federal legislation.

Medical benefits through COBRA follow the same restrictions and guidelines as the state's group health plans. Benefits are outlined in the employee *Insurance Handbook* and the *Plan Document*.




**STATE GROUP
INSURANCE
PROGRAM**

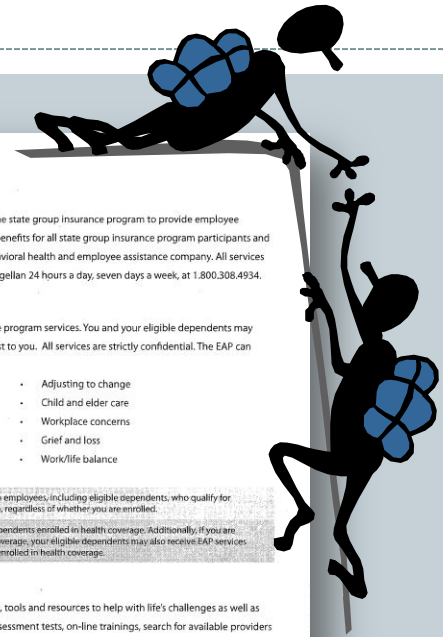
**NOTICE OF
PRIVACY
PRACTICES**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Please review this
notice carefully.**



EAP Information



Employee Assistance Program Mental Health and Substance Abuse Benefits

Welcome!

Magellan Health Services is the company contracted by the state group insurance program to provide employee assistance program, mental health and substance abuse benefits for all state group insurance program participants and eligible dependents. Magellan is the nation's leading behavioral health and employee assistance company. All services are strictly confidential and can be accessed by calling Magellan 24 hours a day, seven days a week, at 1.800.308.4934.

Employee Assistance Program Eligibility

The chart below defines eligibility for employee assistance program services. You and your eligible dependents may receive up to six counseling sessions per episode at no cost to you. All services are strictly confidential. The EAP can handle problems related to:

- Stress
- Depression and anxiety
- Family or parenting issues
- Alcohol or drug dependencies
- Marital or relationship issues
- Adjusting to change
- Child and elder care
- Workplace concerns
- Grief and loss
- Work/life balance

State Plan	State and higher education employees, including eligible dependents, who qualify for enrollment in a health plan, regardless of whether you are enrolled.
Local Education Plan and Local Government Plan	Employees and eligible dependents enrolled in health coverage. Additionally, if you are enrolled in single health coverage, your eligible dependents may also receive EAP services even though they are not enrolled in health coverage.

Online Resources

MagellanHealth.com provides valuable health information, tools and resources to help with life's challenges as well as opportunities. This site offers you the ability to take self-assessment tests, on-line trainings, search for available providers and access Mapquest® links to see a map of your provider's location, as well as obtain driving directions. It also provides the ability to review claims information online. To access the site for the first time, you will be prompted to enter the toll-free EAP number (1.800.308.4934). You may then set up your own unique account number and password for confidential and anonymous access to a wide variety of information and resources.

Mental Health and Substance Abuse Eligibility

You and your dependents must be enrolled in health coverage to be eligible for mental health and substance abuse services. No matter which healthcare option you have selected, you have convenient and confidential access to mental health and substance abuse benefits. Your specific benefit-covered mental health and substance abuse services depend on your particular healthcare option (see grid on reverse side), but services generally include:

- Outpatient assessment and treatment
- Individual and group treatment
- Inpatient assessment and treatment
- Alternative care such as partial hospitalization and intensive outpatient treatment
- Treatment follow-up and aftercare

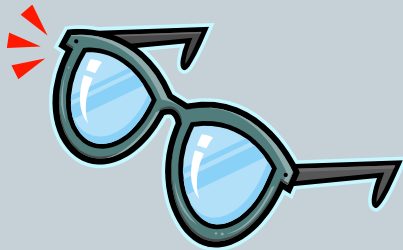
Certain services are specifically excluded under the terms and conditions of the state group insurance program. For more information, contact Magellan Health Services or refer to the Plan Document, available at www.state.tx.us/finance/ins/ or from your agency insurance preparer.



Annual Enrollment Transfer Period



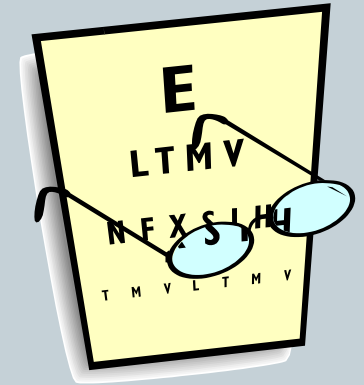
- The insurance enrollment transfer period for 2011 is:
October 1 – November 1
- **This is the ONLY time period** to make changes to your insurance coverage for the year.



Vision & Dental



- Delta Dental and Assurant Dental
- Vision Blue



 DELTA DENTAL



Sick Leave Bank Donation Form

Weakley County Education Association

Sick Leave Bank Donation

PLEASE PRINT:

NAME: _____

Social Security Number: _____

Donation:

Donations shall be made during the months of August, September, or October. The number of days to be donated shall be prescribed by the Committee of Trustees. However, in no case shall the donation exceed three days. When the total sick leave bank balance falls below thirty days, each participating member will be assessed additional days to restore the balance. Donations are nonrefundable and nontransferable.

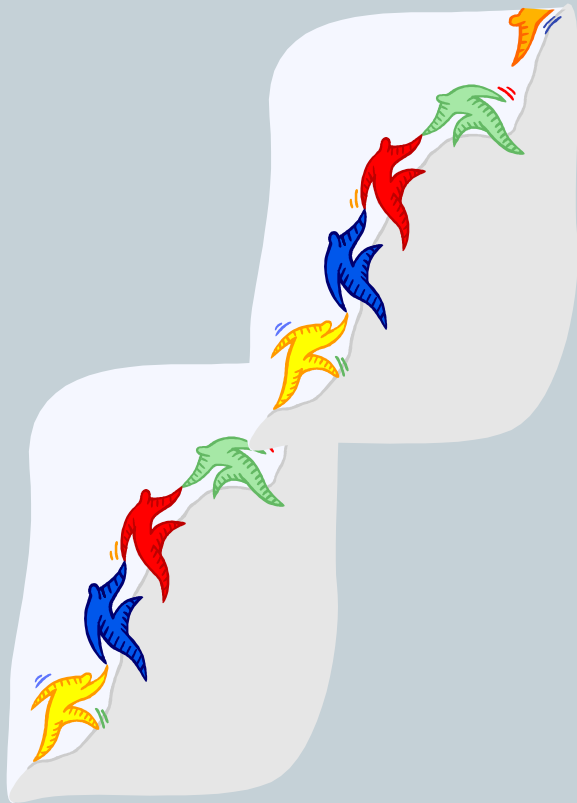
As a certified employee of the Weakley County School System I donate two (2) days to the Sick Leave Bank.

Signature of Employee _____

Date _____



Transfer Sick Leave Form



WEAKLEY COUNTY DEPARTMENT OF FINANCE

Shawn Francisco, Director of Finance

8319 Highway 22, Suite B

Dresden, TN 38225

E-mail: franciscos@k12tn.net

www.weakleycountytn.gov

T: (731) 364-5429 F: (731) 364-3858

Please return this form to: Weakley County Department of Finance

8319 Hwy. 22, Suite B

Dresden, TN 38225

Please certify AND have notarized the accumulated sick leave days at the end of the
_____ - _____ school year for the below named teacher.

Teacher

Superintendent/Principal

Sick Days

State of _____

County of _____

Sworn to before me this _____ day of _____, _____

Notary Public

My commission expires: _____

QUESTIONS & APPOINTMENTS



- Welcome to the Weakley County School System!
- Please fill out paperwork and return the documents by **August 10, 2011.**
- We have appointment calendars available-
Be sure to **make your appointment today!**

